State of Illinois
Department of Healthcare and Family Services

C-PAP/BIPAP RENEWAL QUESTIONNAIRE

Date: ____________________ Patient Name: ____________________

Recipient Identification Number: ____________________ Date of Birth: ____________________

☐ C-PAP ☐ BIPAP

☐ Heated humidifier ☐ Non-heated humidifier

Above equipment has been approved for dates of service ____________ to ____________

1. Date patient last seen: ____________ Current weight: ________ Previous weight: ________
2. Is patient still using C-PAP/BIPAP successfully? ☐ Yes ☐ No

If yes, please document resolution of symptoms:

____

____

3. What is the Plan of Care?

____

____

4. Is surgical intervention an option? ☐ Yes ☐ No

If YES, explain: (Has patient been referred to a specialist? Include dates and results of referral.)

____

____

5. Please indicate duration of need:

____

____

6. C-PAP/BIPAP Manufacturer: ____________________

Model: ____________________ Serial Number: ____________________

Copies of ALL follow-up sleep studies to include impression and recommendations, and copy of compliance download from the past 30 days should be attached.

____________________ ____________________

Physician Signature Date